JCAHO HOT TIPS 2001:

CONSULTATIONS:

1. On our admission assessment we have numerous triggers for automatic consultations.

For example, we request a:

- **PT/OT consult** for unsteady walk/falls, unable to transfer
- self from bed, Chair, or toilet, if patient is paralyzed, or if patient scores as a high risk for falls.
- **Speech Path** consult for swallowing problems/dysphagia,
- abnormal speech.
- **Nutrition consult** for patient with HIV/Aids, wt loss of 10 lbs. in 6 months, on nutritional supplements at home, appetite poor at home, patient below 87% ideal body weight,
- **OT consult** if patient unable to bath, dress, toilet, or feed self, if patient had paralysis or upper Ext. weakness,
- **Social Service consult** if pt. needs interpreter, will require assistance at home, lives in a nursing home, personal care home, or boarding home. If patient used home care, community support groups, adult day care or transportation services prior to admission. If pt uses recreational drugs.

> **Geriatric Nurse Practitioner** consult if patient has cognition problems or scores as a high risk for falls.

- **Skin Care consult** for skin tears, decubiti, lacerations, wounds, or drainage
- **Medical Photography** consult for ecchymosis, wounds, skin tear, and decubiti.
- **Automatic triggers** are denoted by an abbreviation in the box associated with the assessment area.
- Abnormal Speech SP

ASSESSMENT OF PATIENTS

POLICY

The care or treatment provided to each patient at West Virginia University Hospitals shall be based on patient's needs as determined through the assessment of patient's relevant physical, psychological, and social status.

The assessment includes the collection, analysis, and integration of data to identify and prioritize the patient's needs for care or treatment, to determine the need for any additional data, and to determine the care or treatment to be provided. The scope and intensity of assessments are determined by the patient's diagnosis, the treatment setting, the patient's desire for treatment, and

the patient's response to any previous treatment. When appropriate, data from the patient's significant other(s) are included.

PROCEDURE:

I. The following further defines the scope of assessment performed per discipline and the timeframes for completion of initial assessments and further reassessments.

A. **Medical Staff Assessment:**

Initial Assessment - performed by the Medical Staff no more than seven (7) days before admission or within 24 hours after admission. The Medical staff determines which tests, if any are to be performed when the patient enters the service or setting. Patients admitted to the RDSU for a diagnostic procedure require a H & P.

Reassessment - performed ongoing based on patient need, treatment regime, treatment setting, and patient response to care or treatment or at minimum daily.

Documentation - initial assessments (H & P) is documented in the Staff Notes within 7 days prior to admission or within 24 hours after admission. Subsequent assessments will be documented in the Staff Notes.

B. Anesthesia Assessment:

Initial Assessment - a pre-anesthesia assessment is Performed by an Anesthesiologist on each patient for whom anesthesia is contemplated within one week prior to surgery. The post operative status of the patient is assessed by an Anesthesiologist on admission to and discharge from the PACU (Postanesthesia Care Unit).

Reassessment - performed immediately pre-induction and throughout surgical case or procedure.

Documentation - assessments is documented in the Staff Notes and on the Anesthesia Record.

C. Hospital Dentistry

Initial Assessment - Assessment of inpatients with dental disease that affects their care is available through Hospital Dentistry. The initial assessment will occur within 24 hours of the consultation made by the patient's medical team and will be completed by Hospital Dentistry or the Oral Surgeon on call. Assessments are triggered by a consultation placed for the following reasons:

-victims of emergency and trauma to the head and neck regions.
-poor dentition leading to altered nutrition or problems in managing other medical conditions.
-dental care for patients residing in the facility or for patients who can expect a prolonged length of stay (> 30 days).

Reassessment - Performed based on patient need, treatment regime, treatment setting, and patient response to treatment.

Documentation - Assessments are documented in the Staff Notes within 24 hours. Subsequent assessments will be documented in the Staff Notes.

D. Nursing Care Needs Assessment:
Initial Assessment - A Registered Nurse assesses the patient's need for nursing care in all settings in which nursing care is provided within 8 hours of admission. Data collection for aspects of the initial nursing assessment may be delegated to the LPN and Clinical Associate in accordance with applicable law and regulation. The assessment of infants, children, and adolescents specifically includes the patient's developmental age, length/height, head circumference, and weight, consideration of educational needs and daily activities, and the patient's immunization status. In addition, the family's and/or guardian's expectations for, and involvement in, the assessment, treatment, and continuous care or treatment of the patient must also be included. The Registered Nurse analyzes information obtained in the patient assessment and draws conclusions to determine and prioritize the patient's nursing care needs.

Reassessments - each patient is reassessed at regularly specified times as related to approved Standards of Practice, the patient's course of treatment, to determine the patient's response to treatment, when a significant change occurs in the patient's condition, and when a significant change occurs in the patient's diagnosis, or at minimum every 48 hours for acute care or once per week for long-term care.

Documentation - the initial assessment is documented on the Plan of CareInitiation Form and includes evaluation of biophysical, psychosocial, educational, discharge planning, environmental, spiritual/cultural and self-care factors. Reassessments performed will be documented on the patient care record, nursing flowsheet, or Care Map (as applicable).

E. Nutritional Needs Assessment:

Nutrition and Dietetics
Initial Assessment - The patient is screened on admission by the RN for nutritional risk factors. If the patient meets defined high-risk criteria, a "high-risk notification" for the clinical Dietitian is initiated; these patients are assessed within 24 hours of identified need. Consults and high-risk diagnoses are assessed by a Dietitian within 24 hours of identified need.

Reassessments - Reassessments should be documented at least every 7-10 days.

Documentation - All assessments are documented in the Staff Notes.

F. Discharge Planning Needs Assessment:
1. Nursing
Initial Assessment - Initial assessment of discharge needs is performed by the Registered Nurse at the time of admission. Referral to Social Services based on initial assessment triggers for those patients requiring a more extensive evaluation of needs.
Reassessment - performed daily by the Registered Nurse.
Documentation - Initial Nursing assessments should be documented on the Admission Database; subsequent assessments will be documented on the Nursing Flowsheet or Plan of Care.

2. Social Services Assessment
Initial Assessment - initiated by consult or high risk screens (e.g., age, diagnoses, readmission status, insurance coverage) for extensive evaluation of discharge needs, coordination of services, and access to community resources within 24 hours of consult or identified need.

Reassessments - performed on an on-going basis, when contacted for reevaluation, or at minimum every 3 days.

Documentation - all assessments are documented in the Staff Notes.

G. Psychosocial Needs Assessment:

1. **Nursing**

Initial Assessment - performed by the Registered Nurse at the time of admission.

Reassessment - each patient is reassessed at regularly specified times as related to approved Standards of Practice, to determine the patient's response to treatment, when a significant change occurs in the patient's condition, and when a significant change occurs in the patient's diagnosis, or at minimum every 48 hours for acute care or once per week for long-term care.

Documentation - initial assessment performed by Nursing is documented on the Admission Database. Subsequent assessments will be documented on the Nursing Flowsheet.

ADDITIONAL ASSESSMENTS:

1. **Physical Therapy**

Initial Assessment - initiated by consult or Physicians Orders for Physical
Therapy indicated for evaluation and treatment, evaluation and
recommendation, accessing of equipment or home programs to meet discharge
needs, or for therapy as specified in the Physicians Order and completed
within 24 hours of initial consult or order.

Reassessment - performed ongoing based on treatment regime and are protocol driven.

Documentation - all assessments are documented in the Staff Notes.

2. **Occupational Therapy**

Initial Assessment - initiated by consult or Physicians Orders for Occupational Therapy indicated for evaluation and treatment, evaluation and recommendation, accessing of equipment or home programs to meet discharge needs, or for therapy as specified in the Physicians Order and completed within 24 hours of initial consult or order.

Reassessment - performed ongoing based on treatment regime and are protocol driven.
Documentation - all assessments are documented in the Staff Notes.

3. **Speech Therapy**
Initial Assessment - initiated by consult or Physicians Orders for Speech Therapy indicated for evaluation and treatment, evaluation and recommendation, accessing of equipment or home programs to meet discharge needs, or for therapy as specified in the Physicians Order and completed within 24 hours of initial consult or order.
Reassessment - performed ongoing based on treatment regime and are protocol driven.
Documentation – all assessments are documented in the Staff Notes.

4. **Spiritual Needs Assessment**:
Initial Assessment - performed by the Registered Nurse at the time of admission with consultation follow-up available through the Pastoral Care Department indicated as follows:
a. persons who have received difficult information regarding their illness.
b. persons who are at the later state of dying.
c. family members who are present when a patient has died.
d. individuals who indicate that their illness has invoked an interest in discussing spiritual issues.
e. when patients lack pastoral care support from their home community.
Reassessment - Ongoing reassessments are provided by Nursing, Pastoral Services, and Social Services based on patient need and patient desire for follow-up.
Documentation - Nursing assessments are documented on the Nursing Flowsheet or Plan of Care. All Social Service or Pastoral assessments will be documented in the Staff Notes.

5. **Palliative Care Assessment**:

Initial Assessment - Palliative Care Consultation assessments are initiated by caregiver patient/family request for evaluation of patients with chronic or terminal illness by a written physicians order after discussion with the attending physician. The initial assessment will include a history, physical examination, review of the patient's medications and examination of the medical record and will be completed with 48 hours of consult.

Reassessment - ongoing reassessments are performed based on identified needs and plan of care goals and may include collaboration with the medical social worker, chaplain, or other appropriate health care disciplines.
Documentation - Consultation findings, assessment, and recommendations are documented in the Staff Notes.

6. **Pain Management Assessment:**
Initial Assessment - performed by the Registered Nurse at the time of patient admission.
Reassessment - ongoing reassessments are performed as per pain management standard of practice. Pain Service consultations are available 24 hours/day, 7 days/week via pager 362-1975 (M-F 8 am to 4 pm) or pager 362-8799 after 4 pm weekdays, and all day on weekends/holidays.
Documentation - Initial Nursing assessments are documented on the Plan of Care Initiation Form. Subsequent assessments are documented on the Pain Intensity Scale and the Patient Care Record/Nursing Flowsheet. Pain Service consultation findings and assessments are documented in the Staff Notes.

7. **Respiratory Services Assessment**:
Initial Assessment - initiated by consult or Physicians Order for Respiratory Therapy and completed within 4 hours of consult or order.
Reassessment - performed ongoing based on initial assessment findings or at minimum every 48 hours.
Documentation - all assessments are documented in CHIP under Ancillary Notes-Respiratory Care. Hard copy of documentation will be filed in the front of patient's chart included within the CHIP daily summary report.

8. **Pharmacy Assessment**:
Initial Assessment - assessments are performed based on drug orders (e.g., drug-food interactions, dose/pharmacokinetic parameters).
Reassessment - performed based on ordered drug therapy and profile review.
Documentation - assessments will be documented in the Pharmacy Intervention
Pathway and are not a part of the permanent medical record.

9. **Emergency Department/Service Needs Assessment**:
Initial Assessment - all patients presenting in the Emergency Department are triaged by a Registered Nurse or

an Emergency Department Physician upon arrival and are assigned one of three triage categories (emergent, urgent, non-urgent) as further defined in the unit specific policy. The timeliness of Medical Staff assessment is based on the triage classification.
Reassessment - performed ongoing based on patient need, patient diagnosis, patient acuity, Standard of Practice, or patient response to care or treatment.
Documentation - recorded on the Emergency Department Record.

10. **Assessment of Alleged/Suspected Victims of Abuse**: Refer to Hospital Administration Policies on Victims of Alleged/Suspected Domestic Violence/Physical Abuse (III.085; Elder Abuse (III.095); Child Abuse and Neglect (III-090); and Sexual Assault (III.080).

11. **When behavioral health or substance-abuse services** determine that multidisciplinary treatment plans are appropriate, the following addresses these multidisciplinary treatment plans?
A. All departments have established lines of communication with the medical staff. Policies and/or standards exist to direct their practice. Input from all involved disciplines of the health care team as well as the patient and his/her significant others are solicited and considered in developing and modifying the treatment plan.
B. Physician involvement in and approval of the multidisciplinary treatment plan is required.

In acute areas - A treatment plan is initiated within 8 hours of admission.
The initial treatment plan is fully developed within 72 hours and is approved by at least the patient, the physician, the nurse, and the clinical therapist.
Treatment rounds occur on a daily basis for every patient. The treatment team consists of at least the physician and will include at least one of the following disciplines: nurse, therapist, discharge planner,mental health associate. Revisions to the treatment plan occur based on the patient's needs.
In residential areas - The initial treatment plan is initiated within 8 hours of admission. The initial treatment plan is fully developed within 14 days of admission and is approved by at least the patient, the physician, the nurse, and the clinical therapist.

Treatment rounds occur on a daily basis for every patient. The treatment team consists of at least the physician and will include at least one of the following disciplines: nurse, therapist, discharge planner, mental health associate.
Revisions to treatment plans in residential areas occur on a regular basis, but no less than once in each calendar month.

SAFETY:
The American National Standard (ANSI) Z358.1-1998- references requirements for emergency eyewash and shower equipment. There are standards for both the hand-held drench hoses and combination units (shower and eye wash). In general the requirements are to be activated weekly and inspected annually to assure conformance to the ANSI standards.

The criteria you should use are those in OSHA's Hazard Communications standards, 1910.1200 (I believe in paragraph b, but don't have it in front of me)

JCAHO expects you to have a hazardous materials program which is consistent with the OSHA Haz Comm Standards. These speak to such things as the pH of alkali and acid materials, corrosivity of materials, etc.
In most cases, you put them in your standards, but they provide little useful guidance, as they are aimed at chemists, not 'normal' users. (This is not to suggest that chemists are not normal. This was a message from my legal panic coordinator)

A commonly used tool for actual inventory is to use the labeling of the chemicals. If the label says "CAUTION", "WARNING", "HAZARD", or "DANGER" they probably should be added to the departments inventory.
Also, ask department heads to use their profesional judgement. If they know it is hazardous, it should be on the inventory.

The existance of an MSDS is not a good criteria, as I have MSDS for water, wood dust, and a host of other non-hazardous materials under normal usage. The MSDS is used by vendors and manufacturers as a liability-limiting tool, and often done for less or non-hazardous materials 'just in case'.

Generally, toner used on copiers and printers are included if they are in an open system (poured from a bottle) but not if they are in a sealed system such as a printer cartridge with a strip you pull off as you install it.

There is some discussion about white-out. It is covered by the exemption about common materials used as normal users use them, as most people use white-out occasionally, not constantly. If an employee does use it in different intensity than a "normal" user, an MSDS would be needed. Unless you paint walls, or huge ammounts of text with white-out , most folk rely on the exemption. (But typical household goods used in a hospital may need MSDS: examples would be housekeeping cleaners, based on the use factor. Dry board eraser would probably also fall under this provision. By the way, rubbing alcohol may work as well, and already be in the inventory.

First off, talk to either your radiology services director, or better yet the Chief Tech in Nuclear Imaging. This topic is the basis from which everything they do evolves. Radioisotopes fall under the NRC (or agreement state) regulatory guidelines. In most cases, the drug is either ordered from an off-site radiopharmacy in a unit dose syringe, or possibly manufactured on-site in the nuclear medicine hot lab using a generator. You need to find out from your chief tech which method they use, or if they do a combination.

The control of hot lab activities falls under the jurisdiction of the Chief Tech and the Radiation Safety Officer. Purchase of radioactive materials (whether unit dose; generator and "cold" kits"; or sealed sources) is handled by the nuclear medicine / radiology service. Dispensing of the radioisotope is done by the nuclear medicine technologist for routine diagnostic procedures; and by the physician for some therapeutic procedures.

Check this website...it has some information that may be beneficial to you and your pharmacy director: http://nuclearpharmacy.uams.edu/

MORTALITY REVIEW:

The Joint Commission standards address mortality review through resuscitation and autopsy review

requirements. Look at Joint Commission standard PI.3.1.1. The intent statement includes outcome of resuscitation services. PI 3.1 includes autopsy results as an element of the performance improvement program and MS.8.5 relates to the medical staff responsibilities of autopsy. Mortality review is the common methodology to meet the above standards requirements.
Additionally, the Conditions of Participation requires a review of "death records to improve identification of potential donors" under the Organ Procurement condition 482.45

RESEARCH

In my experience with previous surveys (I was formerly employed in a Research oriented facility), the surveyors are mainly concerned with issues regarding patient rights and informed consent. Those requirements/standards are spelled out in the Patient Rights/Organizational Ethics section of the CAMH manual.
With some of the adverse publicity associated with clinical research lately, I would assume that there will be some increased scrutiny related to the safety issues, ie the IRB's deliberations about off label usage, evidence of safety, etc.
We do have an in-house IRB and have addressed the consent and confidentiality issues there for all studies at our institution. It would continue to function in this role with the new researcher. But we anticipate some new caveats with the addition of a researcher focused on clinical trials. There has been some discussion about using and external IRB for non-FDA approved drug studies.
So, more questions...
How and what are people reporting up to their Board of Trustees from their IRB?
How involved in the Accreditation process were the actual researchers?
If we did outsource some or all of the IRB, are we opening the whole can of worms related to competencies and other standards?

RESTRAINTS/SECLUSION

JCAHO just put out a clarification of restraint/seclusion standards on their web page that states:
Four requirements must be met for a resident to order restraint or seclusion:

1. The resident meets the state's requirements to practice medicine within the auspices of the training program;
2. The resident has successfully completed the first year of post-graduate medical education;
3. The graduate education program allows the resident to perform this activity; and,
4. The activity is listed in the resident's job description.

What is the web site where the regulations/guidelines can be accessed? www.medlaw.com is a good resource

LABORATORY

Lab is also under CAP and JCAHO. You will probably do fine but any off-site clinics need to be included in your application as they fall under Waived Testing. Also, your off-sites will also be visited by the Lab surveyor who will check on quality control. We received a Type I (WT1.4.1)under the Lab survey because three of our off-site were not properly monitoring, especially Urine Multistix based on manufacturer's recommendations: when opened and monthly thereafter til the bottle is discarded. Hospital cycle is every 3 years, Lab cycle is every 2. This year our surveys fall in the same year. JCAHO/JCR publishes a number of solid resources to help you prepare.

MEDICATION

We have added all of our high alert drugs to the medication administration policy that requires 2 nurses to verify medications prior to administration. This includes things like adrenergic agents, chemotherapy, IV Digoxin, heparin, insulin, IV Lidocaine, narcotics, KCl IV, warfarin, Dopamine and Doputamine. In notifying the patient of patient safety issues, the primary care physician may not be the best person to notify the patient. We address the issue with the care team including the Risk Manager to determine the best person to advise the patient. The primary care physician is directly involved in the process. In developing a "double check" policy you might also want to think about what "checking" means. To some folks it means an independent 5 rights check by another licensed person. To others it means eyeballing the syringe and confirming the number of units that it appears to contain. You're likely to find a lot of variation in how people define checking.

Regarding Stock Meds and Pharamacy:

Recent surveyors have been looking for stock meds. If they found stock, they were recommending stock meds be removed to prevent medication errors. The pharmacy was to be responsible for reviewing all medications orders prior to administration. If unable to do so, the house supervisor or appointed nurse would obtain the medication out of the pharmacy and make a list of drugs removed, so the pharmacist could check those orders in the am. If this occurs, the nurse or supervisor obtaining the drug must have competency to reflect he/she knows how to obtain the

med, dosage, side effects, etc. The surveyor also checked with the pharmacy to see what drugs were high volume of drugs and being given prior to pharmacy review. These medications must be a prn or emergent drug and not routine medication. The pharmacist then reviews all meds that were administered during the night on the following pharmacy check review. The narcotic review should correlate with the narcotic sheets. All the phy, nurse and administrative surveyors checked for double signatures on waste and count of narcotics.

Regarding IV fluids without medication:
The majority of facilities seen throughout my experience have labeled all IV's. The I/O is generally seen documented on the graphic sheet. Stock IV's are not labeled until they are hung on the patient. If we fail to label how can we be certain there are no drugs added to the bag? A patient once received an extra dose of Pitocin when the IV was not labeled. It appeared as only IV fluids, when in fact the night nurse had added Pitocin. The bag was not labeled and medication was not documented on the MAR. Therefore, failing to label in that particular case caused a medication error.

Can anyone tell me what they are doing with the standard that requires pharmacists to review all orders before administration. As far as orders in PACU for pain meds etc. They have narcotics as stock and if they need something, they call the doctor, get the order and administer it. The pharmacist does not see the order until the drug is already given. The same thing happens on the floor. We also carry meds such as phenergan on floor stock and if someone has nausea they get the order from the doctor and give the first dose from floor stock, therefore the pharmacist does not see the order before administration.

ENVIRONMENT OF CARE
Here are a couple of hospital web sites with Environment of Care Plans and Manuals on-line for the public:

University of Kansas Medical Center
http://www2.kumc.edu/safety/index.html

University of Texas Medical Branch @ Galveston
http://webb.utmb.edu/envcare/

Don't think that JCAHO's decision not to include EC in this year's fixed topics of random unannounced surveys means your previous EC Type I's won't be scrutinized?

If you had an EC Type I during your last JCAHO visit, expect surveyors to make sure it's corrected, former JCAHO insider Susan McLaughlin, president, SMB Consulting, Barrington, Ill., said at the recent ASHE meeting in Tampa. Now that patient safety and staffing issues are high on JCAHO's radar, anything you do that intersects those standards will be on JCAHO's hit list (HR.2, p. HR-6; PI.3.1.1, p. PI-11; PI.4.3, p. PI-16; LD.4.3, p. LD-35; LD.3.4.1, LD.4.4, LD.4.4.2, LD.4.4.3 and LD.4.5.5, '01 CAMH) The American Society for Healthcare Engineering (ASHE) has a document called the Hazard Vulnerability Analysis. It's a straightforward grid for the ranking and analysis of human, natural and technological risk. We used it and it passed JCAHCO survey in March of 2001.

Here are some examples of Life Safety Management performance indicators.
Examples of Life Safety Management Performance Indicators

¨ Fire drills - 1 per shift per quarter per building with 2 per shift per quarter in areas under ILSM.
¨ Worker knowledge regarding life safety is tracked with a goal of greater than 90% correct response rate.
¨ Alarms shall sound at least 95% of the times when they are activated on the day shift (due to preventative maintenance the alarms are occasionally silenced) and 100% on the evening and night shifts.
¨ Fire doors shall close and latch 100% of the time.
¨ Fire wall penetrations shall be sealed 100% of the time.
¨ Fire suppression systems shall be tested at least quarterly.
¨ Fire extinguishers shall be tested monthly.
¨ Interim life safety measures shall be implemented when fire protection is compromised.

NOTE: I am cutting & pasting a policy on smoking. It may have lost some formatting, but the info is all there. I hope that this is helpful.

SMOKING
POLICY
West Virginia University Hospitals recognizes its responsibility in the prevention of disease as well as its treatment. Smoking is one of the major causes of disease and death in this country. Therefore smoking is not permitted in any facility owned, leased or operated by West Virginia University Hospitals by any patient, visitor or

employee. Further, since the public look to West Virginia University Hospitals as a center of health and wellness, smoking is also prohibited at all entrances and adjacent areas.

PURPOSE

To reduce the risk to patients associated with smoking and to protect other patients, visitors and staff form the dangers of passive smoke inhalation. To reduce the risk of fire hazard for the protection of patients, staff and visitors and the preservation of the physical plan. To be in compliance with licensing and accreditation standards.

Signs consistent with this policy will be placed at appropriate locations throughout hospital buildings and vehicles.

PROCEDURE:

a.Patients

All patients will be informed of the smoking policy on admission. Patients are not permitted to smoke while in with the exception of the independently ventilated smoking facility adjacent to the hospital on Level 4(see Attachment I).

b.Patients who are unable to refrain from smoking should consult with their physician who may be able to recommend alternatives to smoking. In the event that there is no acceptable alternative for the patient, the patient may smoke in the ventilated smoking facility if the following criteria are met:

1) he/she has an "ad lib" activity order and

2) smoking does not interfere with the patient's care and treatment modalities.

3. Minors will not be allowed to smoke or use tobacco products in this facility at any time.

4. Adult patients are not permitted to smoke or use tobacco while in CRH with the exception of the designated entitled smoking area on the Psychiatric Intensive Care Unit or in the designated outside smoking area (see Attachment I).

5. Patients who are unable to refrain from smoking should consult with their physician who may be able to recommend alternatives to smoking. In the event that there is no acceptable alternative for the patient, as assessed by the RN, the patient may smoke in the ventilated smoking facility per physician protocol if the following criteria are met:

1) patient is able to independently transport self

2) smoking does not interfere with the patient's care and treatment modalities
5. Patients who use tobacco/smoke must keep supplies at the nurse's station if on the Psychiatric Intensive Care Unit. These supplies will be distributed every hour on the hour from 7:00 AM - 11:00 PM for the Psychiatric Intensive Care Unit patients. Other adult patients restricted to the unit will be able to smoke/use tobacco on the Psychiatric Intensive Care Unit accompanied by a staff member two times or more per shift from 7:00 a.m. to 11:00 p.m.
6. Patients will be encouraged to address their smoking needs and will be provided support as necessary to assist them in making non-smoking decisions.
7. Patient exhibits such significant increase in anxiety in response to possible denial of smoking that not smoking would be counter therapeutic to the patient.

8. Visitors:
1). Visitors are mot permitted to smoke while in the hospital
2). All hospital staff are required to help enforce the policy by informing any visitors who may not realize the hospital's policy regarding this matter
4). Visitors are permitted to smoke outside WVUH's buildings in the shaded areas noted on Attachment I.

9. Employees
1). Employees and staff members may not smoke in any area of RMH or CRH or any facility owned, leased or operated by WVUH.
2). Employee and staff lounges, meeting rooms, and private offices are non-smoking areas.
3). The areas adjacent to the hospitals as indicated on Attachment I and II are non-smoking areas.
4). Employee smoking is permitted only in the shaded areas indicated on Attachment I and.
5). Prospective employees will be informed of the hospital's smoking policy during their initial interviews.

10. Compliance
1). Department managers and supervisors are responsible for ensuring employee compliance with this policy. Employee violation of this policy will be handled according to hospital disciplinary procedures as outlined in Hospital Policy V.230, Corrective Action.

CONSCIOUS SEDATION:
Recently there was some discussion re: monitoring of reversal agents used in conscious sedation. Can anyone tell me if there are any specific standards addressing this. What are others doing monitoring numbers- if you are, are you benchmarking against any standards and closing the loop as a p.i. project or just keeping the statistics.

We review every conscious sedation case. I've pasted below the tool that we use to collect data. The nurse recovering the patient is responsible for completing the form. Completed forms are then sent to my department where we enter them into an access data base. Results are trended by physician and sent to the Department Chairman monthly, and presented to the Patient care Management Committee quarterly. The Department Chairman are responsible for taking action if any of their physicians fall out of line with their peers. The Chairman of Anesthesia was involved in the development of the tool and receives monthly reports as well. He works with the other Chairs if there is a problem. Overall failure rates are also included on our Peer Review profiles for re-credentialing.
We currently have 3 quality indicators to monitor for moderate sedation. (However, in October we will begin monitoring 7 indicators!) Of which, reversal agent is one. QI is the keeper of the data, but..we close the loop. Meaning the areas that administer moderate sedation are required to send QI the total number of cases for the month by the 5th of the following month, along with the 'fall-outs'. These 'fall-out' cases are then reviewed by the Chairman, Department of Anesthesia for appropriate use of reversal. If cases are appropriate, i.e. decrease 02 sats, we monitor by stats. However, if the use is inappropriate, i.e. no documentation to support need for reversal, then case is sent to peer review. Data submission to PI Council and Board on quarterly basis.

Regarding Deep Sedation ER Issues:
from a Risk Management point of view....I think you are asking for major liability issues with Deep Sedation in the ER. Depending on your set up, can you adequately monitor the patient or are you having to routinely use reversal agents? ER nurses are great folks, but I've never seen an ER yet that had the time or man-power to adequately monitor

patients with Deep Sedation.....I can hear the plaintiff's attorney questions now!

Concur that if deep sedation is administered in ER it is an accident waiting to happen. Surveyors asked this question during the recent surveys. They looked for the type of drug used for deep sedation. If deep sedation was done, staffing patterns and physician privileges for deep sedation were reviewed. The majority of ER docs do not have privileges to do deep sedation. This is not only a JCAHO issue but also a Liability issue. You may also want to confirm that any radiologist giving conscious sedation has a prvilege to do so, (ie, the radiologist administering or ordering chloral hydrate for a pediatric CT, would require privilege for conscious sedation). You may also want to look out for Diprovan being used for conscious sedation. That will definitely get you cited.

QUALITY IMPROVEMENT TOOL

Physician: _____

Date: _____

1. Documentation of level of consciousness on admission to Recovery Room:
a. * Calm and cooperative
b. * Drowsy/responds to verbal
c. * Sleepy/easy to arouse
d. * Difficult to arouse
e. * Unable to arouse
2. Ability to maintain unassisted airway on admission to Recovery Room:
a. * Assisted
b. * Unassisted
3. Physiological data recorded every 5 minutes during procedure.
a. Continuous ECG Yes * No *
b. Respiratory rate Yes * No *
c. Blood pressure Yes * No *
d. Pulse oximetry Yes * No *
e. O2 saturation Yes * No *
4. Use of reversal medication:
Nalaxone Yes * No * Doses: _____
Physostigmine Yes * No * Doses: _____

Flumazenil Yes * No * Doses: _____

5. Aldrete Score

1 2 3 4 5 6 7 8 9 10

Admission to recovery: * * * * * * * * * *

Discharge from recovery: * * * * * * * * * *

6. Post procedure length of stay (Total Recovery time until patient is clinically ready for discharge):

01 - 30 minutes *

31 - 60 minutes *

61 - 90 minutes *

91 - 120 minutes *

> 121 minutes *

7. O2 saturation < 80% Yes * No *

_____

Signature of RN Completing Form

All patients who receive moderate sedation are required to have a ride home at our facilities. They are informed of this at time of procedure scheduling, and when staff call to PREP patient. If they do not have a ride available, we will call a taxi.

We specify a responsible person must be with patient. This responsible person and patient may take a cab, but some one must know the specific's to moderate sedation, i.e. no smoking except with responsible person, no operating equipment, no driving for 24 hours, no signing of legal documents for 24 hours, etc..

Medical Library IM.9

I don't recall seeing this standard. Can you tell me which one it is?

You do not have to have a library in your hospital but you need to be able to show a contract with a library to provide the service.

Ambulatory Care

The clinics need to look at the standards from their point of view.

Some of the standards, leadership, management, Patient education,etc would be the same for clinics and the hospital. Safety, assessment, infection control, treatment, would have to be individualized to the clinic.

The best thing you can do to prepare is get the staff ready. Mock surveys work well. They are good practice and let you know " the state of the Nation" so to speak.
Each clinic must address safety issues that apply specifically to that clinic.
Don't forget to conduct drills. They are a must and they will check. Be sure the clinic specific information is fed into the hospitals committees such as infection control, safety and quality council.

EMTALA mandates that a medical screening evaluation be done to determine whether a medical emergency exists. The medical screening evaluation includes much more than what is typically performed by the triage nurse. EMTALA also mandates that obtaining insurance/other information cannot delay care or treatment. http:www.medlaw.com is an excellent resource.

"We envision a system of care in which those who give care can boast about their work, and those who receive care can feel total trust and confidence in the care they are receiving." Donald M. Berwick
The problem here is a not uncommon misunderstanding of the difference between triage and a medical screening exam. They are NOT the same.

Someone must, indeed, do a medical screening exam prior to gathering financial information. In my state (California) that can be done by an RN under procedures specific to our state law. In the community hospitals in my area, it's most commonly done by the ED physician however. Yes, this is after the RN triages. And yes, you'll probably have to redesign your systems for registration.

The pertinent law is a federal one - EMTALA. The penalties for being convicted of an EMTALA violation are very severe. You do not want to ignore this one.

Here's a good reference to start with:
http://www.mhf.net/mall/stores/Frew/default.htm

these are the sites i've found useful. hope this is helpful.
m.ingelsby
lowerkeysmedicalcenter
www.emtala.com

http://www.medlaw.com/
http://www.megalaw.com/

iNTERPRETORS:
Generally they take a competency test and should have the certificates available to you. Start at this site: http://www.diversityrx.org/HTML/MOIP.htm

We have a policy, list of interpreters to call, an assessment form to indicate that we have asked the pt/visitor what their choice of communication devices are and a log to track interpreter response, all as dictated by the ADA. Our Social Service Dept. did most of the work in getting a list of interpreters for our use. Some interpreters signed a contract indicating that they would respond in a certain time frame, how much they would get paid and so forth. Others just are on the list indicating that we can contact them. Some sign language interpreters are "qualified" some"certified". I don't know the difference but we had them send us their certificate for our files. I think that "qualified" in American Sign Language is what we looked for. We were fortunate to have an audiologist on staff who knew what to look for.
We actually have native speaking employees who give folks a standard oral test in that particular language. We are a state hospital, and we have many different ethnic backgrounds, but I think if we do not have an employee who speaks a language here, we coordinate it through our main office to another agency or hospital that does
As a former French professor, I'd suggest considering the guidelines established by the American Council on the Teaching of Foreign Languages (http://www.actfl.org/) for testing proficiency. If they seem suitable, you could contact ACTFL to find somebody in your area who could conduct interviews.
However, unless you need some formal documentation, you could also find a local teacher or native who would be able to rate an interpreter's proficiency informally. Of course, the teacher or native would have to be knowledgeable about medical terminology. (ACTFL testers don't necessarily have the specialized vocabulary.) Check with local colleges and universities; you may be able to find a foreign student studying medicine.

Someone on the staff of this organization could help:

http://www.atanet.org/bin/view.pl/181.html I would think it would be important ask an independent non-biased third party fluent in the language the person needs to interpret test and/or evaluate the interpreter...this could be someone with a local organization or association or university or language school...Previous experiences and references would also be good...
There is a certification that translators can get, which means they must pass certain standards. This is not necessarily specific to medical translations, but does ensure at least a minimum competency. Otherwise, you could double check the work, by hiring another translator to proofread, or as back up for an interpreter.
There are two associations that credential interpreters... I don't remember their names, but I found them by doing a Google search.
Back in the late '60's and early seventies when my children were very little and I was wearing the hat of a freelance translator/interpreter, I became affiliated with the American Translators Association. In general, professional translators/interpreters become members of the American Translators Association. For membership they have to be recommended by an established member of the Association. They also have a directory. Therefore, membership in ATA might be a good starting point.
ATA Website URL: http://www.atanet.org

EMPLOYEE PHONE #s – GIVING THEM OUT:
Our employee phone numbers are in the hospital computer under employee locator. Everyone has to sign a confidentiality statement each year and they are aware that they are not to give out phone numbers. Department mangers are to have a hard copy to keep updated in the departments in case of disaster or failure of the system. So you have access to them if you have access to a computer and most employees do at all levels to access messages in the internal e-mail.

PI EFFORTS/TRAINING:
1. I use the White Bead game (or Red bead or whatever you want to call it!) to show the need to review how we do things, how praise, rewards and intimidation do not result in a better work product, etc. Everyone loves that game. You can really play up the inspectors, the consultants, etc.
2. I use the example of the old woman/young woman in Stephen Covey's book (the first 7 habits) to illustrate

being sensitive to the ideas of others; open to the perception of others. I hate to use this buzzword but paradigm shifting is what I am trying to illustrate, to show them that we have changed how we look at quality. I plant a couple of people in the audience to insist the drawing is of an old woman. They argue their position and pretend to not be able to see the young woman.
3. I show examples of statistical tools but use funny situations. Like the flowchart - I show my rework loops of hitting the snooze button or not being able to decide what to eat as I try to get to work on time.
4. I bring in actual PI storyboards for them to get up out of their seats and come look at as I explain our methodology. This helps keep them from falling asleep.
NOTE: The White Bead Game is carried by a number of companies. I purchased mine from http://64.38.99.5/redbead.com/ but you can Google "white bead game" or "red bead game" and find several other vendors.
4. The paradigm shifting illustration comes from Stephen Covey's book "The 7 Habits of Highly Effective People" pages 24-29 and page 45. You can find this book at any library.

NOTE:Good examples of PI tools can be found in just about any statistical analysis book but the one I like the best and that gives healthcare examples is one published by Aspen Publishers. It is an easy read with great tools. The book is called "Managing Outcomes, Process, and Cost in a Managed Care Environment" by Roey Kirk. This is an investment well worth your while. (Shucks, I wish I had some kickback arrangement with Aspen..

EDUCATION:
Consider using self-learning packages. These are presentations (often done in Powerpoint or other presentation programs), and printed on paper, with evaluation tools (tests, etc.) to evaluate the knowledge. If the student/employee can answer the questions, whether they read the self-learning package or not, they are "trained".

This assumes that the learners are literate in the language of the presentation, but an alternate for non-literate people is to have someone read the presentation to them, and ask the questions. Other languages would require a translation of the package and test, just as a live presentation would...

Self learning packages can also be automated, on computers, and the tests done on computers, and thus easily aggregated.

I have worked with several hospitals who have moved their annual continuing education to such packages, and get 100% inclusion.

Fairs, (example: Safety Fairs, for EC issues) are another cost-effective method, often fun to boot. 'Booth' for each topic (a poster presentation, live demo, or similar topical treatment) make up the chapters, and where practical, interaction improves the education ("Try out this fire extinguisher", "Try pulling the fire alarm pull box")etc. often enliven the training, and improve retention. A post-test documents their attendance, and the level of knowledge at the end of the fair.

While there are commercial programs which do this, they are usually expensive, and must be customized to your needs, (more $$). The do-it-yourself approach only needs someone with some skills on Powerpoint or a similar program, (maybe a student at a local business college, or in a communications program at a local college) and content, which your staff has. Even the 'fair' approach is in-expensive, as it concentrates the staff into several hours (over several shifts, to include everyone) and maximizes the interpersonal contact, which improves learning.

EXAMPLE - PERFORMANCE IMPROVEMENT POST TEST

NEW EMPLOYEE ORIENTATION

July 26, 2001

TRUE OR FALSE

1. ONLY THE MANAGERS PARTICIPATE IN PERFORMANCE IMPROVEMENT.
   TRUE **FALSE**

2. THE BOARD OF DIRECTORS HAVE ULTIMATE RESPONSIBILITY FOR THE PERFORMANCE IMPROVEMENT PLAN.
   TRUE **FALSE**

3. PLAN, DO , CHECK, ACT CAN ALSO BE STATED AS PDCA.
   TRUE **FALSE**

4. WHEN A TEAM OF EMPLOYEES MEET TO ADDRESS A PERFORMANCE ISSUE THIS IS REFERRED TO AS A RAPID RESPONSE TEAM.

TRUE **FALSE**

5. AN EXAMPLE OF A SENTINEL EVENT IS AN INFANT ABDUCTION.

TRUE **FALSE**

6. COLLECTING DATA OR SERVING AS A MEMBER OF A RAPID RESPONSE TEAM ARE WAYS THAT YOU MAY PARTICIPATE WITH PERFORMANCE IMPROVEMENT.

TRUE **FALSE**

7. IF YOU INDENTIFY AN AREA THAT YOU THINK NEEDS TO BE IMPROVED YOU CAN NOT MENTION THIS TO YOUR MANAGER AFTER ALL IT IS THEIR JOB TO KNOW THERE IS A PROBLEM.

TRUE **FALSE**

8.THE PERFORMANCE INDICATORS THAT WE MONITOR AND SUPPLY DATA TO JOINT COMMISSION (JCAHO) ARE CALLED ORYX INDICATORS.

TRUE **FALSE**

9.THE MISSION OF PERRY MEMORIAL HOSPITAL IS TO PROVIDE COMPASSIONATE, QUALITY HEALTH SERVICES TO THE PEOPLE AND COMMUNITIES WE SERVE.

T**RUE** **FALSE**

NAME:_____

DEPARTMENT:_____

PACU ISSUES:

Please provide feedback on any experience you may have had with JCAHO Surveyors and their response to narcotics at the bedside for patients in the Post Anesthesia Care Units (PACU) immediately following post-op. We did not have a problem with this last survey (1998) but have heard recently that this was an issue in a neighboring hospital in our community. Our Survey is fast approaching in October of this year, so any feedback you can provide would be helpful!

In our PACU it is common practice for the nurses to titrate pain meds in the recovery room. They may have 10mg of Morphine they sign out from a locked supply, administer

only part of it, leave the syringe at the bedside and return a short time later (5 min or so) to give another dose if needed. The recovery area is a closed unit and the nurses are always present.

Do you allow visitors to your PACU. If 'yes', I would say you are vulnerable. The surveyor will likely argue that the visitors are left alone with the patient while the nurse tends to her other patient(s).
This would allow time for unauthorized access. We went to smaller vials of narcotics to avoid this issue. We have 2mg and 4mg vials of MSO4, for instance. It necessitates more trips to the med cart but staff adjusted. If you look at the TX standard related to control of drugs you would be subject to a finding if you continue to leave unattended drugs at the bedside.. The risks of allowing a narcotic to be left unattended at the bedside goes against what most of us were trained to do while in nursing school-don't leave meds at the patient's bedside. In addition, leaving narcs unattended could lead to risks that others may give a dose without your knowledge, some one may steal the drug or replace the solution,etc. Do you want the hassle of doing a narcotic missing report? Not sure of alternatives (having a brain cramp at the moment) but you in non compliance with the standard.

I observed a survey this week in Dallas and the question was asked in the NICU, PICU, and adult ICUs -- "How do you assess pain in unresponsive patients?" as well as "How do you assess pain in patients on the ventilator and in drug-induced coma?"

PATIENT SAFETY:
"We have been through several surveys in the last three months. The surveyors are quoting an OCT 1, 2001 initiation date to identify a Patient Safety process to analyze and an OCT 1, 2002 date for implementation of the reviewed process. The web site does not reflect these dates. Where can I find the suspense dates for the standard?"
"The implementation of all of the safety standards is **October 1, 2001**. Some went into effect on July 1, 2001, specifically the RI.1.2.2 having to do with notifying patients when outcomes differed from anticipated. The reference to **October 1, 2002** must have to do with organizations collection, analysis and aggregation of data, since one would not be able to see that with an implementation date of 10/01/2001. Hope that helps."

Here is the answer provided by the JCAHO SIG group:

Just today, I spoke with Pat Staton from JCAHO. I asked the exact question(s) What actual JCAHO standards apply? - Specifically

Leadership 5.2, but it is also addressed through other patient safety standards. Pat, also confirmed the need to IDENTIFY one process to put through the excerise of FEMA by 10-01-01. **By July 1, 2002**, this one process must be completed.

To all of you, the FEMA examples are now posted on the HospitalSoup site!

The speaker was Richard J. Croteau, MD., from JCR - his e-mail is Rcroteau@jcaho.org if you have any questions. He liked the first example (Word document) but said the second (Excel spreadsheet) is better because you can assign values & multiply to help prioritize the criticality.

Here are the links to the documents.
<http://www.hospitalsoup.com/policydetails2.asp?PolicyID=7734173> (Excel format)

<http://www.hospitalsoup.com/policydetails2.asp?PolicyID=7734172> (Same document but in html format)

<http://www.hospitalsoup.com/policydetails2.asp?offset=20&PolicyID=7734174> (Sample Failure Mode, Effects and Criticality Analysis for Hypothetical Medication Use Process in OR)

For additional standards questions you might have, please visit our website at www.jcaho.org. Standards Clarification, FAQ's, and the online Standards Question form are all available for your use on the website.

Go to AHIMA web site, www.ahima.org. and scroll down to bottom of page. There is one posted on this web site that you can print

RESTRAINTS:
I am looking for a definition of restraint episode?
I have read conflicting information on this.
Also for acute med surg setting if a patient is in restraints and they are removed for one to two hours then reapplied due to the same behavior, do you consider this a new episode and get a new order? I just asked the same question of 2 surveyor friends of mine. They both said it would be the same event for med/surg patients.

How are you treating side rails? If you put all 4 side rails up, is this a restraint?

During our May HCFA (they were HCFA then) validation survey, bed rails were not an issue at all. Limb and vest restraints were the focus.

It depends. If you put all four up and its a mobility aid, its not a restraint. However if you put side rails up to keep a patient in bed it is a restraint. Side rails for

safety such as on an ER stretcher or in PACU are not considered restraints. To my knowledge, JCAHO does not survey for side rail use, only physical restraints. They do not require you to follow a restraint protocol to have side rails up. However, they do point out that side rails have been associated with injury. Try to keep them down if possible. HCFA/ your state DPH would probably consider side rails a restraint.

I asked the same question of our Continuous Survey Readiness Coordinator who is an employee of JCAHO and she told us that a episode of restraint is as long as the order is written for example if the order was written for 24 hrs that would be 1 episode and for PSYCH if the order was written for 4 hrs that is one episode

Some of you, as did I, may have participated in the Joint Commission Resources audio conference entitled "Restraint and Seclusion" which was broadcast on August 22nd. During the question and answer period following that presentation, a participant asked the question "How does the JCAHO define an episode of restraint?" The answer given was that the JCAHO does not define what constitutes an episode of restraint. The presenter said that each organization must determine their own definition of an episode of restraint. She did provide some examples; an episode could be defined as from the time a restraint is applied until the time it is removed, or whenever an order for restraint is written, or each 24-hour time period.
She was clear, however, that there is no specific JCAHO definition of episode of restraint. Of course, if you are using restraint use as an ORYX indicator, you must use the definition provided by your vendor.

We do have restraint protocols for vented patients that are initiated upon the order of a physician. Restraint is NOT the standard of care for a vented patient, though. We can certainly have a vented patient who is alert enough to not require restraints.

Our criteria for restraining these patients are:
Patient is intubated or has invasive lines where the removal or manipulation of these devices would result in harm to the patient or interruption of treatment for the patient.
Patient is unable to understand and follow verbal, signed or written commands in a language that they understand.

The patient has attempted to remove these devices or has demonstrated non-purposeful movement that places these devices at risk of removal or damage.

Criteria for removal:
The patient no longer has invasive tubes or artificial airway that may be accidentally dislodged, manipulated or damaged.

OR

The patient is able to understand and follow verbal, signed or written commands in language that they understand.
AND
The patient is no longer at risk of dislodging, manipulating or damaging the invasive lines or artificial airway.

These patients are considered "restrained" and are counted in the restraint numbers. Care, assessment and documentation does not differ for these patients.

CRITICAL THINKING:
Anyone have an educational presentation of any description for “Critical Thinking"?? If so, and you would be willing to share?
We have used an excellent site
http://nursing.umaryland.edu/students/~jkohl/scenario/opening.htm
which consists of scenarios and vingnettes that allow this thinking to be exhibited. Once you get into the site, click "begin" and the first situations will come up - followed by a series of questions.

ADVANCED DIRECTIVES:
In the new Update3 to the CAMH the RI.1.2.5 has added a new sentence in the intent that "in the absence of the actual directive, and in accord with applicable state law, the patient's wishes may be documented in the patient's medical record." That phrase "May be" is causuing us some major grief in interpretation. I would like to know how others are interpreting this and what measures you have put into place to do this.
"May be" was "Must be" at our previous JCAHO survey in 1998. We got a type 1 in Pt. Rights because we didn't document patient's wishes in lieu of a copy of their advance directive. Since then we document within 24 hours

the patient's wishes in their own words on the Progress Record, even if later we can get a copy of the advance directive.

If we are unable to find out their wishes we document we are unable and the reason why. I would certainly treat it as "must be".

We resolved this issue by creating a form and having the nurse ask the patient. The patient can write in the "substance" or if the patient cannot respond and tell you the wishes that is documented. If the patient can tell you but cannot write it out for some reason the nurse can note the patient states. The family is asked to bring the directive but if the directive is not there when the iniital nursing assessment is done the "substance" must be documented on the form. The intent of the standard does not require that the physician do this. This has worked for us through the last two surveys.

As do many other organizations, we continually struggle with getting the substance of the Advance Directive documented on the chart when the actual Directive isn't available. Our current policy specifies that if a copy of the AD cannot be obtained within 24 hours, then the substance of the AD must be documented by the MD at that point. Unfortunately, 2 problems exist: 1) communicating with the MD that he/she needs to have & document that conversation, and 2)getting it documented in a timely manner.

We've been thinking that an ideal solution may be to incorporate the Advance Directive into the H&P. The nurse would still need to do follow-up re: getting the actual copy, or providing AD information to those who would like it.

Including it on a short-form H&P is a good idea but will accomplish the issue in only one area. I am increasingly recommending to physicians that are complaining about completing H&P's on time to use at least the H&P portion of the nursing admission H&P as a guide for dictation. Having advanced directives in a prominent place on this record should assist physicians in documenting it in their formal H&P. It's worth a shot.

MEDICAL RECORDS

Question for all of you out there in JCAHO-land who have been recently = surveyed: When the closed medical record reviews were performed, did the = surveyor, accompanied by several hospital staff, review chart documents = that were provided by the staff (each of whom had a chart) in response to = the surveyor's request, OR did the surveyor go through the charts = him/herself, looking for the documents they wanted? There is a need to = know here in=20

Regarding medical record review for K-Zoo Michigan:
During our recent 7 surveys, the surveyors reviewed both ways. The majority
of the time, the surveyors, Phy. and nurse had the team review the record.
The surveyors would call out what they were looking for and determine the %
records containing the information. The other surveys included both the team
and the surveyors reviewing charts. Majority of the chart review was done
concurrently on open records. If the surveyors saw a trend while making
rounds, they would dig deeper into the closed medical record review.

At each of the 20 surveys in our system survey this year, it was very much the old-style medical record review with the entire review team doing one or two charts and the team leader overseeing the review. Home care charts were reviewed separately by the home care surveyor.
At the one new facility not surveyed by our system team, the two surveyors used the new system in which they did the review with one staff member to assist them in finding the documentation they could not locate.
It seems to me that the whole process is **still** driven by individual surveyor preference.

Just completed our survey 2 weeks ago! We did goood.....
First- the surveyors gave us very specific information requesting certain charts for review...i.e. first patient discharged in October 2000 with diagnosis of chest pain or last patient in ED in November2000 with moderate sedation etc.
Second- surveyors had color coded specific standards for review. Medical Records then tabs the colors to meet the standard, i.e. blue for initial H&P, yellow for advance

directives etc. These tabs were put on the above charts for easy 'finds' during review.
Third- two staff members were requested for each surveyor to assist in validating that standards were met according to the color codes. In addition to this, the surveyors reviewed the charts, utilizing staff for additional information.
We found the survey to be in-depth, fair, but most of all, said they would not be back for 3 years!

t the end of day one the nurse surveyor provided medical records with a
list of charts they wanted.
It went something like this. First C section after 4/1/2001 mom and babe.
First vaginal birth after 2/1/2001, mom and babe. First four restraint
charts since 1/1/2001. First five ED restraint charts since 1/1/2001.
First five transfers from ED to higher level of care since 2/1/2001. First
CHF since 12/1/2000. They asked for some surgeries etc. In all there were
10 inpatient charts and 15 ED charts. They excused all the participants of
the IS/HIM interview expect those who needed to stay.
1 Med Rec supervisor and 2 RN with chart review experience stayed along with
myself. The nurse and MD divided the charts and looked for certain
elements. They gladly let us help them and though they were through they
were fair.

CPR:
We do accept medical excuses but require that the staff member participate
in the training to the extent to which he/she is able. The manager is
expected to evaluate the situation to determine if the staff member with
limitations is able to fulfill his/her role expectations through assignment
adjustments or other accomodations. If limitations would result in the
inability to quickly resuscitate a patient, the staff member may need to be

reassigned. I'm not aware that this has ever been the case.
In our institution we accept the physician's note saying they can not do the physical part, however, there are parts they can do such as respirations, calling the code, bringing the equipment for others etc. We do not give them a reason to believe they have no responsibility for CPR. None of our staff work alone no matter what the census is so they are there to support others. We have them attend the class and not do the parts the doctor says they are unable to perform.
Here is how we define it.

- All Duke University Hospital employees with patient care responsibilities must successfully complete BLS Health Care Provider (BLS-HCP) training and renewal every two years. This is inclusive of, but not limited to, housestaff, licensed nurses, nursing care assistants (NCAs), transporters, respiratory therapists, operating room technicians and attendants, radiologic technicians, cardiac cath technicians, physical therapists, patient access services employees and occupational therapists. Competence may be demonstrated by:
  - Maintaining current evidence of BLS training according to AHA or American Red Cross criteria.
  - Maintaining current BLS Instructor, Instructor Trainer or Affiliate Faculty status.
  - All Duke University Hospital employees with patient contact must be trained and maintain renewal every two years in one of the following categories:
    - Heart Saver: Comfortable with adult one rescuer CPR and obstructed airway infant and child prn). No written test.
    - Code 5 Recognition and Notification: Recognize an arrest situation and react accordingly:
    - Recognize unresponsiveness, pulselessness and absence of breathing
    - Know how and who to call for help (i.e. verbally, 115, 911)
    - Validation and documentation of compliance with this policy will be the responsibility of each department head.

We do, but it needs to be a medical excuse and we need to have a new excuse Every two years. If the reason was lack of stamina, this would not be acceptable. This reason would not prevent them from taking a CPR course and at least

intiating CPR! If they truly had lack of stamina how are they working!
We still mandate that they take the written exam at least every 2 years (actually found that some were being excused because they did not want to take the test and when we mandated this, miracle of all miracles, some of the previously excused became capable of physically doing CPR). In addition, you want to assess if this is a problem for the individual dept. For example, we only had 3 RN/LPN on night shift on a small step down geriatric unit. Out of the 3, 2 had medical excuses. This was unsafe and we had to transfer 1 to another shift so that we had the majority of staff capable of doing CPR.

MEDICAL STAFF – RESIDENTS - GME

Standard MS.6.9

In hospitals participating in a professional graduate education program(s), the medical staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each participant in the program(s) in carrying out patient care responsibilities.2

Standard MS.6.9.1

There is a mechanism for effective communication between the committee(s) responsible for professional graduate education and the medical staff and governing body.

The intent includes:

Written descriptions of the role, responsibilities, and patient care activities of participants in professional graduate education programs are provided to the medical staff. These descriptions include identification of the mechanisms by which the participant's supervisor(s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities. Medical staff rules and regulations and policies also delineate those participants in professional education programs who may write patient care orders, the circumstances under which they may do so (without prohibiting LIPs from writing orders), and what entries, if any, must be countersigned by a supervising LIP.

Residents may only perform deep sedation if the attending with the same privilege is present. They may however perform moderate sedation without
their attending if the attending has the privilege. All residents must complete the same requirements as our regular medical staff (view the video
and have a passing score. We also require all residents to be ACLS certified because they respond to our codes. This has been our process through at least 2 surveys and there haven't been any problems

Recent mock survey. Protective services for us was an issue. How do other facilities notify patients of services available to them. Do you post any where? Do you provide

to patients where to file a complaint? We added an area in our patient had book that addresses filing grievances.

ACTUAL JCAHO SURVEY QUESTIONS WORLD-WIDE AND MEDCOM MTF AFTER ACTION REPORTS FROM PREVIOUS SURVEYS: